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ABSTRACT

College students (N=396), chronic pain patients (N=319), and schizophrenic veterans (N=43) completed the Depression Coping Questionnaire (DCQ) and the Beck Depression Inventory (BDI). Factor analysis of the DCQ identified eleven coping responses: social support, problem solving, self-blame/escape, aggression, indulgence, activities, medication, stimulation, eating, television, and ignoring. Multiple regression analyses indicated that the DCQ contributed significant variance in predicting BDI scores of men and of women. Both men's and women's BDI scores were positively correlated with age, self-blame/escape, medication, and television and negatively correlated with social support, problem solving, and indulgence. Men's BDI scores were positively correlated with stimulation and aggression and negatively correlated with ignoring. Four discriminant functions were identified in a discriminant analysis comparing nine groups made up of veterans and of depressed and nondepressed male and female college students and male and female pain patients. Function 1 discriminated college students from other participants on a dimension ranging from indulgence (college students) to medication and stimulation (others). Function 2 discriminated between depressed and nondepressed participants on a dimension ranging from high (depressed) to low (nondepressed) use of self-blame/escape. Function 3 discriminated men from women on a dimension ranging from indulgence, television, and activities (men) to social support, problem solving, self-blame/escape, and eating (women). Function 4 discriminated veterans from other participants on a dimension ranging from ignoring and stimulation (veterans) to aggression and television (others). These results and results from previous research suggest that coping styles are predictive of depression. (Six pages of references, five tables, and one figure are included.) (Author/NB)

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The Depression Coping Questionnaire

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Abstract

Participants from three population samples (396 college students, 319 chronic pain patients, 43 schizophrenic veterans) completed the Depression Coping Questionnaire (DCQ) and the Beck Depression Inventory (BDI). Factor analysis of the DCQ identified eleven coping responses: social support, problem solving, self-blame/escape, aggression, indulgence, activities, medication, stimulation, eating, TV, and ignoring. Multiple regression analyses indicated that the DCQ contributed significant variance in predicting BDI scores of men ($\underline{R}$ = .705) and women ($\underline{R}$ = .568). Both men's and women's BDI scores were positively correlated with age, self-blame/escape, medication and TV and negatively correlated with social support, problem solving, and indulgence. In addition, men's BDI scores were positively correlated with stimulation and aggression and negatively correlated with ignoring. Four discriminant functions were identified in a discriminant analysis comparing nine groups made up of veterans and of depressed and nondepressed male and female college students and male and female pain patients. Function 1 discriminated college students from other participants on a dimension ranging from indulgence (college students) to medication and stimulation (others). Function 2 discriminated between depressed and nondepressed participants on a dimension ranging from high (depressed) to low (nondepressed) use of self-blame/escape. Function 3 discriminated men from women on a dimension ranging from indulgence TV, and activities (men) to social support, problem solving, self-blame/escape, and eating (women). Function 4 discriminated veterans from other participants on a dimension ranging from ignoring and stimulation (veterans) to aggression and TV (others). Results were integrated with findings from previous research. Discussion focused on the question of whether coping styles are best assessed by instruments that measure broad categories of coping responses for general situations or by instruments that focus on what people do for specific problems.

The Depression Coping Questionnaire

In their book, Stress, Appraisal, and Coping, Lazarus and Folkman (1984) outline the processes of cognitive appraisal and coping, that are both relevant to the study of depression. Many researchers have recognized the interaction between cognitive appraisal and depression by investigating attributional styles of depressed and nondepressed people (Abramson, Seligman, & Teasdale, 1978; Burger, 1984; Coyne & Gotlib, 1983; Eaves & Rush, 1984; Golin, Sweeney, & Schaeffer, 1981; Gong-Guy & Hammen, 1980; Hammen & Cochran, 1981; Krantz & Rude, 1984; Lewinsohn, Steinmetz, Larson, & Franklin, 1981; Martin, Abramson, & Alloy, 1984; Pietromonaco & Markus, 1985; Raps, Peterson, Reinhard, Abramson, & Seligman, 1982; Tabachnik, Crocker, & Alloy, 1983).

Coping styles of depressed and nondepressed people have also come under scientific scrutiny. Coyne, Aldwin, and Lazarus (1981) asked depressed and nondepressed participants in a community survey to report on the Ways of Coping checklist (Folkman & Lazarus, 1980; Lazarus & Folkman, 1984) how they coped with a recent stressful event. Depressed people gave significantly greater endorsement to help-seeking/avoidance and to seeking emotional support. No differences were present between depressed and nondepressed people on the following coping scales: problem-focused, growth-oriented, minimizes threat, and self-blame. Billings, Cronkite, and Moos (1983) compared responses of depressed outpatients and nondepressed controls on three domains of coping: appraisal-focused, problem-focused, and emotion-focused. Depressed patients reported more use of information seeking and emotional discharge and less use of problem-focused coping than did nondepressed controls. Billings and Moos (1984) reported that problem-solving and affective-regulation styles of coping were negatively correlated with depressive symptoms and that

emotional discharge and avoidance styles of coping were positively correlated with depressive symptoms.

The present study was directed toward a more specific examination of the relation between coping responses and depression. Of particular interest were the following two questions.

1. What strategies for coping with depression are positively and negatively correlated with depressive symptoms?
2. Is there a reliable difference between depressed and nondepressed men and women from various backgrounds in use of strategies for coping with depression?

In answering the above questions, the research reported here allows us to reach some meaningful conclusions about the reliability and predictive and discriminative validity of the Depression Coping Questionnaire (Kleinke, 1984a; Kleinke, Staneski, & Mason, 1982).

Several factors differentiate this study from previous research on coping with depression. First, the present study focuses on coping strategies that are specific to depression. Researchers have developed a number of scales for assessing general coping styles that can be applied in a variety of situations (Billings & Moos, 1981; Folkman & Lazarus, 1980; Lazarus & Folkman, 1984; Pearlin & Schooler, 1978; Stone & Neale, 1984). The Depression Coping Questionnaire includes a particular set of acts that are related to the specific context of experiencing depression (see Lazarus & Folkman, 1984, p. 298). A second difference between this study and previous research is the use of multivariate statistics (Kaplan & Litrownik, 1977) for comparing depression coping strategies reported by depressed and nondepressed men and women from various age groups and backgrounds. Multivariate statistics were also employed to assess the variance contributed by specific coping responses in predicting depression scores on the Beck Depression Inventory (Beck, 1967).

Method

Research Participants

There were 369 male and 389 female participants in this study who came from the following three population samples.

College students. A random sample of students from colleges in Massachusetts and California included 200 men and 196 women ranging in age from 17 to 59 years.

Pain patients. A random sample of 126 men and 193 women participating in a 28-day inpatient program for chronic pain patients ranging in age from 18 to 83 years.

Veterans. A random sample of 43 men ranging from 25 to 58 years of age who were in their first week of hospitalization on the acute psychiatric ward of a Veterans Administration hospital. All veterans carried a diagnosis of schizophrenia and had at least one previous psychiatric hospitalization. All veterans were stabilized with psychotropic medication.

Procedure

Participants voluntarily completed the Depression Coping Questionnaire (DCQ; Kleinke, 1984a; Kleinke et al., 1982) and the Beck Depression Inventory (BDI; Beck, 1967). All responses were anonymous.

Results

Factor Analysis of DCQ

DCQ responses from the total sample of 758 participants were factor analyzed with a principal components solution and varimax rotation. Eleven interpretable factors were identified (see Table 1). These coping factors were given the following labels: social support, problem solving, self-blame/escape, aggression, indulgence, activities, medication, stimulation, eating, TV, ignoring. Similar factors were identified when separate factor analyses were conducted for men and women, and for participants within each sample.

Insert Table 1, Table 2, and Table 3 about here

Relation Between BDI Scores and Coping Factors

Multiple regression analyses were computed using participants' scores on the 11 coping factors to predict their BDI scores. Age was entered into the multiple regression analysis first, followed by entry of 11 coping factors with a forward inclusion method and an entry criterion of $p < .05$.

Data for men. Multiple regression analysis on data from male participants resulted in an $R = .705$, $F(10, 358) = 38.1$, $p < .0001$. It can be seen in Table 2 that high BDI scores were correlated with age and with the following coping factors: self-blame/escape, stimulation, medication, aggression, and TV. Low BDI scores were correlated with social support, problem solving, indulgence, and ignoring.

Data for women. Multiple regression analysis on data from female participants resulted in an $R = .568$, $F(7, 381) = 25.7$, $p < .0001$. It can be seen in Table 3 that high BDI scores were correlated with age and with the following coping factors: medication, self-blame/escape, and TV. Low BDI scores were correlated with social support, problem solving, and indulgence.

Discriminant Analysis on Nine Comparison Groups

Participants were divided into the following nine comparison groups: depressed college men, nondepressed college men, depressed college women, nondepressed college women, depressed male pain patients, nondepressed male pain patients, depressed female pain patients, nondepressed female pain patients, veterans. Participants with a BDI score of 13 or greater were defined as depressed and those with a BDI score less than 13 were defined as nondepressed.[1] Mean ages and BDI scores for participants in these nine groups are reported in Table 4. It is seen that pain patients and veterans were older and more depressed than college students.

Insert Table 4, and Table 5 about here

Data from a stepwise discriminant analysis using a Wilks' solution and entry criterion of $F = 1$ are reported in Table 5. All 11 coping factors contributed significant variance ($p < .01$) and all nine comparison groups (except depressed male and depressed female pain patients) differed significantly from each another (ps from .05 to .0001). Four significant discriminant functions were identified. For Function 1: Wilks' lambda = .387, $p < .0001$, explained variance = .529; Function 2: Wilks' lambda = .616, $p < .0001$, explained variance = .216; Function 3: Wilks' lambda = .764, $p < .0001$, explained variance = .148; Function 4: Wilks' lambda = .889, $p < .0001$, explained variance = .060. Discriminant analysis data reported in Table 5 indicate that Function 1 is positively associated with medication and stimulation and negatively associated with indulgence. Function 2 is positively associated with self-blame/escape. Function 3 is positively associated with indulgence, TV, and activities and negatively associated with social support, problem solving, self-blame/escape, and eating. Function 4 is positively associated with ignoring and stimulation and negatively associated with aggression and TV.

Inspection of centroids for the nine comparison groups suggests the following conclusions (see Figure 1). Function 1 discriminates college students from veterans and pain patients on a dimension ranging from indulgence (college students) to medication and stimulation (veterans and pain patients). Function 2 discriminates between depressed and nondepressed participants on a dimension ranging from high (depressed) to low (nondepressed) use of self-blame/escape. Function 3 discriminates men from women on a dimension ranging from indulgence, TV, and activities (men) to social support, problem solving, self-blame/escape, and eating (women). Function 4

Insert Figure 1 about here

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discriminates veterans from other participants on a dimension ranging from ignoring and stimulation (veterans) to aggression and TV (other participants).

Discussion

The influence of coping on adjustment has received a good deal of attention, with research on how people cope with marital problems (Mehaghan, 1982), community living (McCrae & Costa, 1986), back pain (Rosenstiel & Keefe, 1983), donating blood (Kaloupek, White, & Wong, 1984), genital herpes (Manne & Sandler, 1984), abortion (Major, Mueller, & Hildebrandt, 1985), offensive behaviors (Barth, Schinke, & Maxwell, 1983), aging (Lazarus & DeLongis, 1983), test anxiety (Sarason, 1984), interview anxiety (Heimberg, Keller, & Peca-Baker, 1986), breast cancer (Taylor, 1983), rape (Janoff-Bulman, 1979), chronic illness (Felton & Revenson, 1984), and daily events (Folkman & Lazarus, 1980). The present study contributes to this zeitgeist by adding to our understanding of several issues related to coping and depression.

Several coping factors identified by the DCQ contributed significant variance in predicting participants' BDI scores. Although the coping factors were entered into multiple regression equations for men and women in somewhat different orders, the results were very similar. For both men and women, high BDI scores were correlated with self-blame/escape, medication, and TV. Low BDI scores were correlated with social support, problem solving, and indulgence. In addition, mens' BDI scores were positively correlated with stimulation and aggression and negatively correlated with ignoring. Although the DCQ accounts for somewhat more variance in predicting depression scores than the more general coping scale employed by Billings and Moos (1984), the conclusions of these studies are similar. Billings and Moos' emotional discharge measure, which is comparable to the stimulation factor, was positively correlated with depression. Billings and Moos' information seeking measure, which is comparable to the social support factor, was negatively correlated

with depression. Finally, Billings and Moos' problem solving measure was negatively correlated with depression, as was problem solving in the present study. Because Billings and Moos (1984) used a different measure of depression (Spitzer, Endicott, & Robins, 1978), it appears that the correlation between coping styles and depressive symptoms is robust.

The coping factors identified in this study can also be related to data reported by McCrae and Costa (1986). Escape/self-blame and aggression are comparable to McCrae and Costa's coping mechanisms that were correlated with neuroticism (self-blame, hostile reaction) and that were ranked relatively low in effectiveness. Social support and problem solving are comparable to McCrae and Costa's coping mechanisms that were correlated with extraversion and openess (seeking help, self-adaptation) and that were ranked relatively high in effectiveness. Medication, which was positively correlated with BDI scores, correlated with neuroticism in McCrae and Costa's study (sedation) and was ranked as moderate in effectiveness. Ignoring, which correlated negatively with males' BDI scores, was correlated with neuroticism, extraversion, and openess in McCrae and Costa's study (distraction) and was ranked as moderate in effectiveness.

In addition to predicting BDI scores, the DCQ also discriminated nine comparison groups including schizophrenic veterans and depressed and nondepressed male and female college students and pain patients. The DCQ offered more elaborate and specific discrimination than the coping measures used in previous research, but some comparisons are possible. As in the Billings et al. (1983) study, emotion discharge (medication, stimulation) was characteristic of patient populations in the present study (Function 1). The higher use of self-blame/escape reported by depressed participants (Function 2) parallels use of wishful thinking and avoidance by depressed people in Coyne et al.'s (1981) study. Coyne et al. (p. 446) explained why

seeking emotional support might be characteristic of depressed people in their study while social support was characteristic of nondepressed (female) participants in the present study by pointing out that help seeking and help getting are two different phenomena. The higher use of problem solving by nondepressed women in the present study parallels results of Billings et al. (1983). Sex differences in coping (Function 3), with women endorsing social support, self-blame/escape, problem solving, and eating and men endorsing indulgence, TV, and activities, are consistent with previous research (Chino & Funabiki, 1984; Funabiki, Bologna, Pepping, & FitzGerald, 1980; Hammen & Padesky, 1977; Padesky & Hammen, 1981). A final result of interest was that schizophrenic veterans reported greater use of ignoring and and stimulation and less use of TV and aggression than other participants (Function 4).

One methodological question in coping research is whether coping styles are best assessed by instruments that measure broad categories of coping styles for general problems or by instruments (such as the DCQ) that focus on what people do for specific problems. A taxonomy of generic coping styles that could predict adjustment in a variety of situations would be most useful in principle because of its generality. However, attitude-behavior research suggests that the predictive power of general self-report measures is low (Ajzen & Fishbein, 1977; Kleinke, 1984b; Wicker, 1969). Self-report scales appear to have greater predictive power when they focus on specific responses to particular situations. A study by McCrae (1984) supports the argument for specific coping measures by showing that people choose different coping responses for different kinds of stressors.

In light of the high correlation between coping styles and depression scores identified in this study, it will be useful in future research to identify causality. Existing research data suggest that coping styles and

depression influence each other. The present results and those of Billings and Moos (1984) indicate that coping styles are predictive of depression. Studies of depressed and nondepressed people's attributional styles cited in the introduction of this article offer examples of how depressive cognitions affect coping. The influence of coping on depression is apparent in therapeutic programs where depressed people are taught many of the coping styles that were negatively correlated with depression in the present study (Beck, Rush, Shaw, & Emery, 1979; Lewinsohn, 1974). It is encouraging that the results reported here are consistent with clinical experience and practice.

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Footnote

1. A BDI score of 13 was used as a cutoff point in order to obtain a sample of depressed college students large enough for data analysis. A person with a BDI score of 13 can be described as mildly depressed (Bumberry, Oliver, & McClure, 1978; Hammen, 1980; Hatzenbuehler, Parpal, & Matthews, 1983; Oliver & Simmons, 1984).

Table 1

Factor Analysis of DCQ

Factor 1--Social Support [a]
Explained variance = 13.2%; Alpha = .73, Reliability = .89

1. I seek out groups of friends or close people. (.78)

17. I get together with one very close person or friend. (.75)

27. I talk with other people and try to work out a plan to to make myself feel better. (.70)

29. I laugh and try to find humor in my situation. (.56)

Factor 2--Problem Solving
Explained variance = 10.5%, Alpha = .67, Reliability = .50

5. I meditate or do other things to relax myself. (.69)

16. I work with myself and try to work out a plan to make myself feel better. (.69)

24. I confront my feelings and try to figure out what is bothering me. (.66)

25. I engage in some sort of creative activity like writing, reading, drawing, playing music, or working on projects. (.61)

Factor 3--Self-Blame/Escape
Explained variance = 6.0%; Alpha = .58; Relaibility = .61

22. I blame myself for feeling depressed. (.71)

21. I cut down on my other responsibilities for awhile. (.61)

14. I daydream and fantasize. (.55)

10. I spend time alone. (.49)

9. I sleep a lot. (.48)

8. I cry. (.48)

Factor 4--Aggression
Explained variance = 5.4%; Alpha = .67; Reliability = .55

3. I become aggressive and feel like fighting. (.85)

20. I become irritable and short-tempered. (.73)

Table 1 (continued)

Factor 5--Indulgence
Explained variance = 5.3%; Alpha = .54; Reliability = .87

12. I smoke marijuana. (.71)

28. I drink alcoholic beverages. (.69).

23. I engage in sexual behavior (of any kind). (.58)

Factor 6--Activities
Explained variance = 4.5%; Alpha = .54; Reliability = .92

13. I go for a walk or short trip. (.77)

26. I go to places where there are lots of people like clubs or dances. (.61)

19. I engage in physical activities like sports, dancing, or jogging. (.55)

Factor 7--Medication
Explained variance = 4.2%; Alpha = .46; Reliability = .91

15. I take stimulating drugs (like amphetamines). (.77)

18. I take tranquilizers (like valium). (.75)

Factor 8--Stimulation
Explained variance = 3.6%; Alpha = .45; Reliability = .80

7. I drink more tea or coffee. (.80)

4. I smoke cigarettes. (.64)

Factor 9--Eating
Explained variance = 3.5%; Relaibility = .68

2. I eat a lot. (.83)

Factor 10--TV
Explained variance = 3.3%; Reliability = .71

6. I watch TV. (.81)

Factor 11--Ignoring
Explained variance = 3.1%; Reliability = .45

11. I ignore the problem and think about other things. (.79)

[a] One-month test-retest correlations for an independent sample of 50 college students.

Table 2

Multiple Regression Predicting Men's BDI Scores

Coping Factor	Multiple R	Beta	Simple r
age	.361	.235***	.36***
Factor 3--Self-Blame/Escape	.534	.261***	.34***
Factor 8--Stimulation	.596	.235***	.42***
Factor 1--Social Support	.633	-.122**	-.28***
Factor 7--Medication	.664	.213***	.39***
Factor 2--Problem Solving	.676	-.146***	-.23***
Factor 4--Aggression	.685	.134**	.31
Factor 5--Indulgence	.694	-.130*	-.06
Factor 10--TV	.700	.100*	.16**
Factor 11--Ignoring	.705	-.088	-.13

*p < .05

**p < .01

***p < .001

Table 3

Multiple Regression Predicting Women's BDI Scores

Coping Factor	Multiple R	Beta	Simple r
age	.331	.285***	.33***
Factor 7--Medication	.463	.272***	.36***
Factor 3--Self-Blame/Escape	.504	.184***	.15**
Factor 1--Social Support	.530	-.090*	-.25***
Factor 2--Problem Solving	.540	-.203***	-.20***
Factor 10--TV	.561	.177***	.17***
Factor 5--Indulgence	.568	-.087*	-.09*

*p < .05

**p < .01

***p < .001

Table 4

Mean BDI Scores and Ages for Nine Comparison Groups

		BDI		Age	
Comparison Group	n	M	SD	M	SD
Nondepressed College Men	165	4.75[a]	3.24	21.5[a]	3.80
Nondepressed College Women	165	4.83[a]	3.71	23.4[a]	6.69
Nondepressed Female Pain Patients	60	7.60[b]	3.27	42.5[c,d]	13.7
Nondepressed Male Pain Patients	49	8.67	2.79	40.2[b,c]	14.1
Depressed College Men	31	17.7[c]	4.08	22.5[a]	7.01
Depressed College Women	35	18.9[c,d]	5.80	23.2[a]	6.29
Depressed Male Pain Patients	77	21.0[d]	7.07	45.9[d]	14.7
Veterans	43	22.3[d]	11.2	35.5[b]	8.26
Depressed Female Pain Patients	133	22.5[d]	7.53	46.1[d]	14.4

Note.--For BDI, $F(8, 749) = 189$, p .0001. For age, $F(8, 749) = 88$, $p < .0001$. Means not sharing common superscript differ beyond $p < .01$ by Duncan's range test.

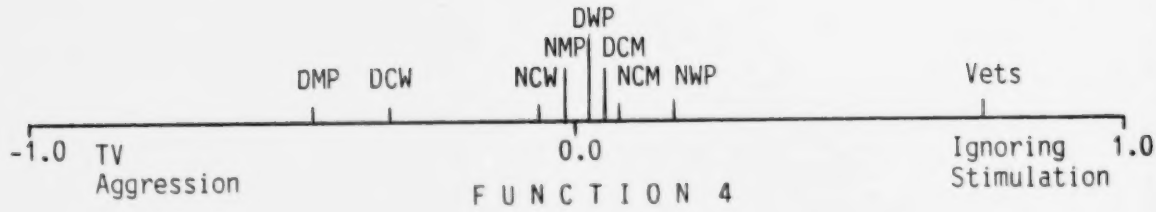
Table 5

Discriminant Analysis on Nine Comparison Groups

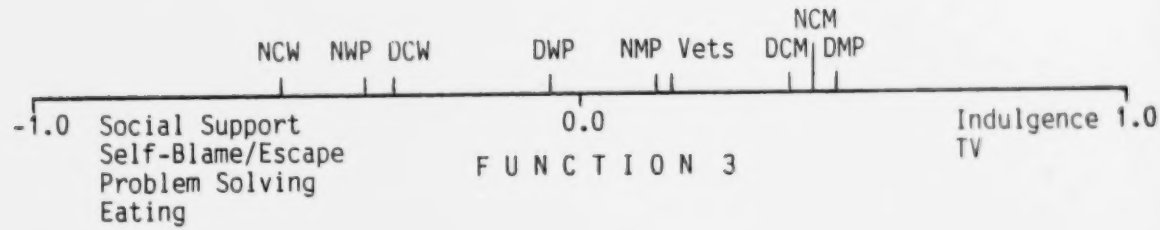
Coping Factor	Standardized Discriminant Function Coefficients			
	Function 1	Function 2	Function 3	Function 4
1 Social Support	-.042	-.209	-.575	.166
2 Problem Solving	-.134	-.221	-.413	.162
3 Self-Blame/Escape	.065	.736	-.420	.112
4 Aggression	-.076	.147	.202	-.413
5 Indulgence	-.639	.090	.500	.150
6 Activities	-.269	.307	.357	.201
7 Medication	.602	.089	.078	.198
8 Stimulation	.476	.165	-.144	.396
9 Eating	-.014	-.003	-.316	-.262
10 TV	.381	-.047	.459	-.422
11 Ignoring	.132	-.190	.381	.407

Figure Caption

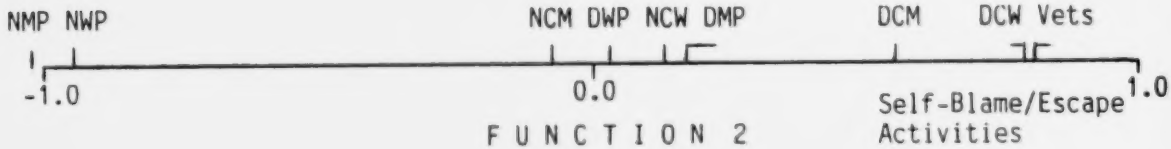
Figure 1. Group centroids on four significant discriminant functions for the following nine comparison groups: depressed college men (DCM), nondepressed college men (NCM), depressed college women (DCW), nondepressed college women (NCW), depressed male pain patients (DMP), nondepressed male pain patients (NMP), depressed women pain patients (DWP), nondepressed women pain patients (NWP), schizophrenic veterans (Vets).



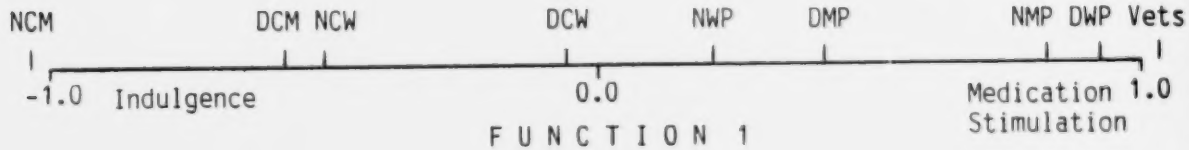
FUNCTION 4



FUNCTION 3



FUNCTION 2



FUNCTION 1